WISCONSIN WELL WOMAN PROGRAM
BREAST CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when submitting claims for ForwardHealth.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID
Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider
Required. Enter the billing provider's name.

Element 3 — Taxonomy Code
Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code
Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member
Required. Enter the member's last name.

Element 6 — First Name — Member
Required. Enter the member's first name.

Element 7 — Middle Initial — Member
Enter the member's middle initial.

Element 8 — Previous Last Name — Member
Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number
Required. Enter the member ID.

Element 10 — Date of Birth
Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS

Element 11 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a mammogram.

Element 12 — Name — Rendering Provider
Enter the name of the rendering provider.

Element 13 — RESULT
Required if this procedure is performed. Check one box only to reflect results of mammogram. If shaded result is selected, follow up is required.

BREAST CONSULTATION

Element 14 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a breast consultation.

Element 15 — Name — Rendering Provider
Enter the name of the rendering provider.

Element 16 — RESULT / RECOMMENDATION
Required if this procedure is performed. Check one box only to reflect the results of the breast consultation. If shaded result is selected, follow up is required.

BIOPSY

Element 17 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a biopsy.

Element 18 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 19 — Biopsy Associated Imaging
Select either “mammogram” or “ultrasound,” if applicable.

Element 20 — RESULT
Required if this procedure is performed. Check one box only to reflect results of biopsy. If shaded result is selected, follow up is required.

FILM COMPARISON

Element 21 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a film comparison.

Element 22 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 23 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the film comparison. If shaded result is selected, follow up is required.

FINE NEEDLE ASPIRATION

Element 24 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a fine needle aspiration.

Element 25 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 26 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the fine needle aspiration. If shaded result is selected, follow up is required.

ULTRASOUND

Element 27 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an ultrasound.

Element 28 — Name — Rendering Provider
Enter the rendering provider's name.

Element 29 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the ultrasound. If shaded result is selected, follow up is required.

Element 30 — NOTES
Enter notes, if applicable.

Element 31 — RECOMMENDATION
This field is required if elements from Additional Mammographic Views, Breast Consultation, Biopsy, Film Comparison, Fine Needle Aspiration, or Ultrasound are completed. Check all applicable boxes.

Element 32 — STATUS OF FINAL DIAGNOSIS
Required. Select one box only to reflect the status of the member's final diagnosis.

Element 33 — FINAL DIAGNOSIS
If "complete" is checked in Element 32, this field is required. Select one box only to reflect the final diagnosis and enter the date in MM/DD/CCYY format.

Element 34 — TUMOR STAGE AND TUMOR SIZE
Check one box to reflect the stage of the member's tumor, if applicable. Enter the size of the member's tumor in centimeters.

Element 35 — TREATMENT STATUS
Check one box only to reflect the member's treatment status.

Element 36 — TREATMENT DATE
Enter date (in MM/DD/CCYY format) as applicable.